STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	290027	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVER C DILS MEDICAL CENTER	700 N SPRING ST, BOX 1010-C-ADM BLDG CALIENTE, NV 89008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Medicare re-certification survey conducted at your facility from September 22, 2008 through September 25, 2008. One complaint was also investigated during the survey. Complaint #NV00012470 was unsubstantiated. The following Conditions of Participations were not met: CFR 482.13: Condition of Participation: Patient's Rights CFR 482.42: Condition of Participation: Infection Control CFR 482.45: Condition of Participation: Organ, Tissue and Eye Procurement The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	A 000		
A 047	482.12(a)(3) MEDICAL STAFF - BYLAWS [The governing body must] assure that the medical staff has bylaws. This STANDARD is not met as evidenced by: Based on interview and review of available documentation, it was determined that the governing body did not assure that the medical staff had current bylaws that reflected the	A 047		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 047	Continued From page 1 Medicare conditions of participation. Findings include: Review of the Medical Staff bylaws provided by the administrator on 9/24/08 revealed they had not been updated since 9/15/98. The medical staff bylaws were not signed by the current governing body or the current chief of the medical staff. The bylaws did not reflect current practices or procedures that were being done by the medical staff. For example the bylaws stated that review was being done of the infection control surveillance information. This was not being done. (see Tag 0749). Interview with the administrator on 9/24/08 confirmed that this was the only set of bylaws and they had not been updated since that 9/15/98.	A 047		
A 048	482.12(a)(4) MEDICAL STAFF - BYLAWS AND RULES [The governing body must] approve medical staff bylaws and other medical staff rules and regulations. This STANDARD is not met as evidenced by: Based on interview and documentation review, it was determined that the facility's governing body failed to approve the medical staff bylaws and other medial staff rules and regulations. Findings include: Review of the Medical Staff bylaws provided by the administrator on 9/24/08 revealed they had not been updated since 9/15/98. The medical staff bylaws were not signed by the current governing body or the current chief of the medical	A 048		

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A 048	Continued From page 2 staff. The bylaws did not reflect current practices or procedures that were being done by the medical staff. For example the bylaws stated that review was being done of the infection control surveillance information. This was not being done. (see Tag 0749). Interview with the administrator on 9/24/08 confirmed that this was the only set of bylaws and they had not been updated since that 9/15/98.	A 048		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on interview and documentation review, it was determined that the facility failed to protect and promote each patient's rights. Findings include: Interview with the assistant administrator, charge nurses, and medical physician and documentation review revealed that the following processes were not in place: CFR 482.13(a)(2) (A118) Patients were not being notified of their ability to file grievances and no process in place to address grievances. CFR 482.13(a)(2) (A119) Patients were not being notified of their ability to file grievances and no process in place to address grievances. CFR 482.13(a)(2) (A120) Patients were not being notified of ability to file grievances and no process in place to address grievances. CFR 482.13(a)(2)(i) (A121) Patients were not being notified of their ability to file grievances and no process in place to address grievances. CFR 482.13 (a)(2)(iii) (A123)Patients were not	A 115		

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A 115	Continued From page 3 being notified of their ability to file grievances and no process in place to address grievances. CFR 482.13(f) (A194) No orientation and reoccurring training being provided on restraints and seclusion. CFR 482.13(f) (1) (A196) No orientation and reoccurring training being provided on restraints and seclusion. CFR 482.13(f)(2) (A199) No orientation and reoccurring training being provided on restraints and seclusion. CFR 482.13(f)(2)(ii) (A200) No orientation and reoccurring training being provided on restraints and seclusion. CFR 482.13(f)(2)(iii) (A201)No orientation and reoccurring training being provided on restraints and seclusion. CFR 482.13(f)(2)(iv) (A202)No orientation and reoccurring training being provided on restraints and seclusion. CFR 482.13(f)(2)(v) (A204)No orientation and reoccurring training being provided on restraints and seclusion. CFR 482.13(f)(2)(vi) (A205)No orientation and reoccurring training being provided on restraints and seclusion. CFR 482.13(f)(2)(vii) (A206) No current first aide and cardiopulmonary resuscitation training, including required periodic recertification being provided to staff. CFR 482.13(f)(3)(A207) No trainer for restraints with the required education, training and experience. CFR 482.13(f)(4)((A208)No documentation of competency in the employees files for restraint training as it relates to the acute hospital setting. CFR 482.13(g) (A214) Seclusion and Restraint No current policy /procedure for the Death reporting requirements.	A 115		

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A 118	482.13(a)(2) PATIENT RIGHTS: GRIEVANCES The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. This STANDARD is not met as evidenced by: Based on interview and review of available documentation, it was determined that the facility failed to establish and implement a process to file grievances and to notify patients of their right to file a grievance. Findings include: Review of the admission packet and the "Patient's Rights" form that was presented in the admission packet to all acute patients or their legal representatives revealed that it did not identify to the patient the right to file a grievance. When the admission coordinator was interviewed on 9/23/08 regarding the lack of notifying the patients of their right to file a grievance, she was unaware of any process in place. Interview with the administrator on 9/24/08 revealed that the administrator was unaware of a process for patients or their legal representative to file a grievance. Review of the acute care policies and procedures manual provided evidence of a policy for "Patient Complaints and Grievances". There was also a "PATIENT COMPLAINTS AND GRIEVANCE" form that the patients could fill out to identify the "Nature of the Grievance". Per interview with the admission coordinator, the administrator and the Director of Nursing were not aware the policy existed.	A 118		
A 119	482.13(a)(2) PATIENT RIGHTS: REVIEW OF	A 119		

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A 119	Continued From page 5 GRIEVANCES [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on interview and review of available documentation, it was determined that the facility's governing body failed to establish and implement a process to file grievances and failed to establish a process to resolve grievances. Findings include: Review of the admission packet and the "Patient's Rights" form that was presented in the admission packet to all acute patients or their legal representatives, revealed that it did not identify to the patient the right to file a grievance. When the admission coordinator was interviewed on 9/23/08 regarding the lack of notifying the patients of their right to file a grievance, she was unaware of any process in place. Interview with the administrator on 9/24/08 revealed that the administrator was unaware of a process for patients or their legal representative to file a grievance. Review of the acute care policies and procedures manual provided evidence of a policy for "Patient Complaints and Grievances". There was also a "PATIENT COMPLAINTS AND GRIEVANCE"	A 119		

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A 119	Continued From page 6 form that the patients could fill out to identify the "Nature of the Grievance". Per interview the admission coordinator, the administrator and the Director of Nursing were not aware the policy existed. There was no evidence that the governing body had approved the policy or was aware of the process.	A 119		
A 120	482.13(a)(2) PATIENT RIGHTS: TIMELY REFERRAL OF GRIEVANCES [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee.] The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum: This STANDARD is not met as evidenced by: Based on interview and review of available documentation, it was determined that the facility failed to establish and implement a process to file grievances and to notify patients of their right to file a grievance and include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the Nevada's quality improvement organization. Findings include: Review of the admission packet and the "Patient's Rights" form that was presented in the admission packet to all acute patients or their legal	A 120		

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A 120	Continued From page 7 representatives revealed that it did not identify to the patient the right to file a grievance. When the admission coordinator was interviewed on 9/23/08 regarding the lack of notifying the patients of their right to file a grievance, she was unaware of any process in place. Interview with the administrator on 9/24/08 revealed that the administrator was unaware of a process for patients or their legal representative to file a grievance. Review of the acute care policies and procedures manual provided evidence of a policy for "Patient Complaints and Grievances". There was also a "PATIENT COMPLAINTS AND GRIEVANCE" form that the patients could fill out to identify the "Nature of the Grievance". Per interview with the admission coordinator, the administrator and the Director of Nursing, they were not aware the policy existed. The policy also did not include a mechanism for timely referral of patients' concerns regarding quality of care or premature discharge to the quality improvement organization.	A 120		
A 121	482.13(a)(2)(i) PATIENT RIGHTS: GRIEVANCE PROCEDURES [At a minimum:] The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital. This STANDARD is not met as evidenced by: Based on interview and review of available documentation, it was determined that the facility failed to establish and implement a process to file grievances and to notify patients of their right to file a grievance.	A 121		

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A 121	Continued From page 8 Findings include: Review of the admission packet and the "Patient's Rights" form that was presented in the admission packet to all acute patients or their legal representatives, revealed that it did not identify to the patients or their representatives the right to file a grievance. When the admission coordinator was interviewed on 9/23/08 regarding the lack of notifying the patients of their right to file a grievance, she was unaware of any process in place. Interview with the administrator on 9/24/08 revealed that the administrator was unaware of a process for patients or their legal representative to file a grievance. Review of the acute care policies and procedures manual provided evidence of a policy for "Patient Complaints and Grievances".. There was also a "PATIENT COMPLAINTS AND GRIEVANCE" form that the patients could fill out to identify the "Nature of the Grievance". Per interview with the admission coordinator, the administrator and the Director of Nursing, they were not aware the policy existed.	A 121		
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.	A 123		

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A 123	Continued From page 9 This STANDARD is not met as evidenced by: Based on interview and review of available documentation, it was determined that the facility failed to establish and implement a process to file grievances and to notify patients of their right to file a grievance. Findings include: Review of the admission packet and the "Patient's Rights" form that was presented in the admission packet to all acute patients or their legal representatives revealed that it did not identify to the patient the right to file a grievance. When the admission coordinator was interviewed on 9/23/08 regarding the lack of notifying the patients of their right to file a grievance, she was unaware of any process in place. Interview with the administrator on 9/24/08 revealed that the administrator was unaware of a process for patients or their legal representative to file a grievance. Review of the acute care policies and procedures manual provided evidence of a policy for "Patient Complaints and Grievances". There was also a "PATIENT COMPLAINTS AND GRIEVANCE" form that the patients could fill out to identify the "Nature of the Grievance". Per interview with the admission coordinator, the administrator and the Director of Nursing, they were not aware the policy existed.	A 123		
A 194	482.13(f) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or Seclusion: Staff Training Requirements. The patient has the right to safe	A 194		

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A 194	Continued From page 10 implementation of restraint or seclusion by trained staff. This STANDARD is not met as evidenced by: Based on interview and review of documentation, it was determined that the facility failed to provide direct care staff and the medical staff with current training on the use of physical restraints in orientation and on a reoccurring basis. Findings include: Interview with the charge nurse on 9/23/08 regarding the use of restraints revealed that she had worked at the facility for a number of years. When asked about the use of restraints she stated that they did not use restraints on the acute floor but occasionally restraints had been utilized in the Emergency Room to protect the patient or staff. However she did agreed that there may come a time when a restraint may be utilized on the acute floor for the same reason. When asked about training on restraints she stated she had attended training for restraint use in the past. Further questioning revealed that this training was directed at the use of restraints in the distinct part skilled nursing unit. No recent training had been provided by the facility to the direct care staff on the use of restraints. Interview with the medical director revealed that he had not been provided by the hospital staff the updated information on the use of restraints and seclusion in the acute hospital setting. He agreed that there may be a time that a patient would need to be restrained to protect the patient or staff from harm.	A 194		

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A 194	Continued From page 11 Interview with the director of nurses revealed that he was not aware of the reporting requirements for death in restraints. He confirmed that there had been no current training on restraints usage for the acute hospital. He was unaware of what the acute hospital's policy stated regarding the use of restraints. Review of the hospital's policy revealed the components of an accurate policy except for the reporting of death in restraints to CMS and when it should be implemented. Although the hospital was not accredited by The Joint Commission, the policy also made reference to The Joint Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy.	A 194		
A 196	482.13(f)(1) PATIENT RIGHTS: RESTRAINT OR SECLUSION Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion- (i) Before performing any of the actions specified in this paragraph; (ii) As part of orientation; and (iii) Subsequently on a periodic basis consistent with hospital policy. This STANDARD is not met as evidenced by: Based on interview and review of documentation, it was determined that the facility failed to provide	A 196		

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A 196	Continued From page 12 direct care staff and the medical staff with current training on the use of physical restraints in orientation and on a reoccurring basis. Findings include: Interview with the charge nurse on 9/23/08 regarding the use of restraints revealed that she had worked at the facility for a number of years. When asked about the use of restraints she stated that they did not use restraints on the acute floor but occasionally the use of restraints had been utilized in the Emergency Room to protect the patient or staff. However she did agreed that there may come a time when a restraint may be utilized on the acute floor for the same reason. When asked about training on restraints she stated she had attended training for restraint use in the past. Further questioning revealed that this training was directed at the use of restraints in the distinct part skilled nursing unit. No recent training had been provided by the facility to the direct care staff on the use of restraints. Interview with the medical director revealed that he had not been provided by the hospital staff the updated information on the use of restraints and seclusion in the acute hospital setting. He agreed that there may be a time that a patient would need to be restrained to protect the patient or staff from harm. Interview with the director of nurses revealed that he was not aware of the reporting requirements for death in restraints. He confirmed that there had been no current training on restraints usage for the acute hospital. He was unaware of what	A 196		

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A 196	Continued From page 13 the acute hospital's policy stated regarding the use of restraints. Review of the hospital's policy revealed the components of an accurate policy except for the reporting of death in restraints to CMS and when it should be implemented. Although the hospital was not accredited by The Joint Commission, the policy also made reference to The Joint Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy.	A 196		
A 199	482.13(f)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Training content. The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following: (i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion. This STANDARD is not met as evidenced by: Based on interview and review of documentation, it was determined that the facility failed to provide direct care staff and the medical staff with current training on the use of physical restraints in orientation and on a reoccurring basis on techniques to identify staff and patient behaviors, events and environmental factors that may trigger	A 199		

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GROVER C DILS MEDICAL CENTER	700 N SPRING ST, BOX 1010-C-ADM BLDG CALIENTE, NV 89008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 199	Continued From page 14 circumstances that require the use of a restraint or seclusion. Findings include: Interview with the charge nurse on 9/23/08 regarding the use of restraints revealed that she had worked at the facility for a number of years. When asked about the use of restraints she stated that they did not use restraints on the acute floor but occasionally the use of restraints had been utilized in the Emergency Room to protect the patient or staff. However she did agree that there may come a time when a restraint may be utilized on the acute floor for the same reason. When asked about training on restraints she stated she had attended training for restraint use in the past. Further questioning revealed that this training was directed at the use of restraints in the distinct part skilled nursing unit. No recent training had been provided by the facility to the direct care staff on the use of restraints. Interview with the medical director revealed that he had not been provided the updated information on the use of restraints and seclusion in the acute hospital setting. He agreed that there may be a time that a patient would need to be restrained to protect the patient or staff from harm. Interview with the director of nurses revealed that he was not aware of the reporting requirements for death in restraints. He confirmed that there had been no current training on restraints usage for the acute hospital. He was unaware of what the acute hospital's policy stated regarding the use of restraints.	A 199		

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A 199	Continued From page 15 Review of the hospital's policy revealed the components of an accurate policy except for the reporting of death in restraints to CMS and when it should be implemented and techniques to identify staff and patient behaviors, events and environmental factors that may trigger circumstances that require the use of a restraint or seclusion. Although the hospital was not accredited by The Joint Commission, the policy also made reference to The Joint Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy.	A 199		
A 200	482.13(f)(2)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (ii) The use of nonphysical intervention skills. This STANDARD is not met as evidenced by: Based on interview and review of documentation, it was determined that the facility failed to provide direct care staff and the medical staff with current training on the use of physical restraints in orientation and on a reoccurring basis regarding the use of nonphysical intervention skills. Findings include:	A 200		

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A 200	Continued From page 16 Interview with the charge nurse on 9/23/08 regarding the use of restraints revealed that she had worked at the facility for a number of years. When asked about the use of restraints she stated that they did not use restraints on the acute floor but occasionally the use of restraints had been utilized in the Emergency Room to protect the patient or staff. However she did agree that there may come a time when a restraint may be utilized on the acute floor for the same reason. When asked about training on restraints she stated she had attended training for restraint use in the past. Further questioning revealed that this training was directed at the use of restraints in the distinct part skilled nursing unit. No recent training had been provided by the facility to the direct care staff on the use of restraints. Interview with the medical director revealed that he had not been provided the updated information on the use of restraints and seclusion in the acute hospital setting. He agreed that there may be a time that a patient would need to be restrained to protect the patient or staff from harm. Interview with the director of nurses revealed that he was not aware of the reporting requirements for death in restraints. He confirmed that there had been no current training on restraints usage for the acute hospital. He was unaware of what the acute hospital's policy stated regarding the use of restraints. Review of the hospital's policy revealed the components of an accurate policy except for the reporting of death in restraints to CMS and when	A 200		

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A 200	Continued From page 17 it should be implemented. The policy did address some nonphysical intervention skills. Although the hospital was not accredited by The Joint Commission, the policy also made reference to The Joint Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy.	A 200		
A 201	482.13(f)(2)(iii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (iii) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition. This STANDARD is not met as evidenced by: Based on interview and review of documentation, it was determined that the facility failed to provide direct care staff and the medical staff with current training on choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition in their physical restraint training.. Findings include: Interview with the charge nurse on 9/23/08 regarding the use of restraints revealed that she	A 201		

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A 201	Continued From page 18	A 201		

had worked at the facility for a number of years. When asked about the use of restraints she stated that they did not use restraints on the acute floor but occasionally the use of restraints had been utilized in the Emergency Room to protect the patient or staff. However she did agree that there may come a time when a restraint may be utilized on the acute floor for the same reason.

When asked about training on restraints she stated she had attended training for restraint use in the past. Further questioning revealed that this training was directed at the use of restraints in the distinct part skilled nursing unit. No recent training had been provided by the facility to the direct care staff on the use of restraints.

Interview with the medical director revealed that he had not been provided the updated information on the use of restraints and seclusion in the acute hospital setting. He agreed that there may be a time that a patient would need to be restrained to protect the patient or staff from harm.

Interview with the director of nurses revealed that he was not aware of the reporting requirements for death in restraints. He confirmed that there had been no current training on restraints usage for the acute hospital. He was unaware of what the acute hospital's policy stated regarding the use of restraints.

Review of the hospital's policy revealed the components of an accurate policy except for the reporting of death in restraints to CMS and when it should be implemented. Although the hospital was not accredited by The Joint Commission, the policy also made reference to The Joint

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A 201	Continued From page 19 Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy.	A 201		
A 202	482.13(f)(2)(iv) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (iv) The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia). This STANDARD is not met as evidenced by: Based on interviews and review of documentation, it was determined that the facility failed to provide direct care staff and the medical staff with current training on the use of physical restraints in orientation and on a reoccurring basis on the safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress. Findings include: Interview with the charge nurse on 9/23/08 regarding the use of restraints revealed that she had worked at the facility for a number of years.	A 202		

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A 202	Continued From page 20 When asked about the use of restraints she stated that they did not use restraints on the acute floor but occasionally the use of restraints had been utilized in the Emergency Room to protect the patient or staff. However she did agree that there may come a time when a restraint may be utilized on the acute floor for the same reason. When asked about training on restraints she stated she had attended training for restraint use in the past. Further questioning revealed that this training was directed at the use of restraints in the distinct part skilled nursing unit. No recent training had been provided by the facility to the direct care staff on the use of restraints. Interview with the medical director on 9/24/08 revealed that he had not been provided the updated information on the use of restraints and seclusion in the acute hospital setting. He agreed that there may be a time that a patient would need to be restrained to protect the patient or staff from harm. Interview with the director of nurses revealed that he was not aware of the reporting requirements for death in restraints. He confirmed that there had been no current training on restraints usage for the acute hospital. He was unaware of what the acute hospital's policy stated regarding the use of restraints. Review of the hospital's policy revealed the components of an accurate policy except for the reporting of death in restraints to CMS and when it should be implemented. Although the hospital was not accredited by The Joint Commission, the policy also made reference to The Joint	A 202		

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A 202	Continued From page 21 Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy.	A 202		
A 204	482.13(f)(2)(v) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (v) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary. This STANDARD is not met as evidenced by: Based on interview and review of documentation, it was determined that the facility failed to provide direct care staff and the medical staff with current training on the use of physical restraints in orientation and on a reoccurring basis clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary. Findings include: Interview with the charge nurse on 9/23/08 regarding the use of restraints revealed that she had worked at the facility for a number of years. When asked about the use of restraints she stated that they did not use restraints on the acute floor but occasionally the use of restraints had been utilized in the Emergency Room to	A 204		

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A 204	Continued From page 22	A 204		

protect the patient or staff. However she did agree that there may come a time when a restraint may be utilized on the acute floor for the same reason.

When asked about training on restraints she stated she had attended training for restraint use in the past. Further questioning revealed that this training was directed at the use of restraints in the distinct part skilled nursing unit. No recent training had been provided by the facility to the direct care staff on the use of restraints.

Interview with the medical director revealed that he had not been provided updated information on the use of restraints and seclusion in the acute hospital setting. He agreed that there may be a time that a patient would need to be restrained to protect the patient or staff from harm.

Interview with the director of nurses revealed that he was not aware of the reporting requirements for death in restraints. He confirmed that there had been no current training on restraints usage for the acute hospital. He was unaware of what the acute hospital's policy stated regarding the use of restraints.

Review of the hospital's policy revealed the components of an accurate policy except for the reporting of death in restraints to CMS and when it should be implemented. Although the hospital was not accredited by The Joint Commission, the policy also made reference to The Joint Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's

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A 204	Continued From page 23 policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy.	A 204		
A 205	482.13(f)(2)(vi) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (vi) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation. This STANDARD is not met as evidenced by: Based on interview and review of documentation, it was determined that the facility failed to provide direct care staff and the medical staff with current training on the use of physical restraints in orientation and on a reoccurring basis. Findings include: Interview with the charge nurse on 9/23/08 regarding the use of restraints revealed that she had worked at the facility for a number of years. When asked about the use of restraints she stated that they did not use restraints on the acute floor but occasionally the use of restraints had been utilized in the Emergency Room to protect the patient or staff. However she did agree that there may come a time when a restraint may be utilized on the acute floor for the same reason.	A 205		

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A 205	Continued From page 24 When asked about training on restraints she stated she had attended training for restraint use in the past. Further questioning revealed that this training was directed at the use of restraints in the distinct part skilled nursing unit. No recent training had been provided by the facility to the direct care staff on the use of restraints. Interview with the medical director revealed that he had not been provided the updated information on the use of restraints and seclusion in the acute hospital setting. He agreed that there may be a time that a patient would need to be restrained to protect the patient or staff from harm. Interview with the director of nurses revealed that he was not aware of the reporting requirements for death in restraints. He confirmed that there had been no current training on restraints usage for the acute hospital. He was unaware of what the acute hospital's policy stated regarding the use of restraints. Review of the hospital's policy revealed the components of an accurate policy except for the reporting of death in restraints to CMS and when it should be implemented. Although the hospital was not accredited by The Joint Commission, the policy also made reference to The Joint Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy.	A 205		
A 206	482.13(f)(2)(vii) PATIENT RIGHTS: RESTRAINT	A 206		

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A 206	Continued From page 25 OR SECLUSION [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification. This STANDARD is not met as evidenced by: Based on interview it was determined that the facility failed to ensure that all staff who apply, monitor, access or provide care for a patient in restraints has received training in the use of first aid techniques (Employee's #1 through #25). Findings Include: On 9/26/08 at 4:55 PM, the director of nurses (DON) was interviewed. He stated that not all of the clinical staff that applied, monitored, assessed or provided care for patients in restraints were trained in first aid. He identified the following employees as needing first aid training: Employee's #1 through #25.	A 206		
A 207	482.13(f)(3) PATIENT RIGHTS: RESTRAINT OR SECLUSION Trainer requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors. This STANDARD is not met as evidenced by: Based on interviews and documentation review it was determined that the facility did not provide	A 207		

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A 207	Continued From page 26	A 207		

training on the use of restraints by an individual who was qualified as evidence by education, training, and experience in techniques to address patients' behaviors.

Findings include:

Interview with the charge nurse on 9/23/08 regarding the use of restraints revealed that she had worked at the facility for a number of years. When asked about the use of restraints she stated that they did not use restraints on the acute floor but occasionally the use of restraints had been utilized in the Emergency Room to protect the patient or staff. However she did agreed that there may come a time when a restraint may be utilized on the acute floor for the same reason.

When asked about training on restraints she stated she had attended training for restraint use in the past. Further questioning revealed that this training was directed at the use of restraints in the distinct part skilled nursing unit. No recent training had been provided by the facility to the direct care staff on the use of restraints.

Interview with the medical director revealed that he had not been provided the updated information on the use of restraints and seclusion in the acute hospital setting. He agreed that there may be a time that a patient would need to be restrained to protect the patient or staff from harm.

Interview with the director of nurses revealed that he was not aware of the reporting requirements for death in restraints. He confirmed that there had been no current training on restraints usage for the acute hospital. He was unaware of what

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A 207	Continued From page 27 the acute hospital's policy stated regarding the use of restraints. Review of the hospital's policy revealed the components of an accurate policy except for the reporting of death in restraints to CMS and when it should be implemented. Although the hospital was not accredited by The Joint Commission, the policy also made reference to The Joint Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy. The Director of Nurses per interview on 9/23/08 stated that no one on the staff had the appropriate education, training and experience in techniques used to address patients' behaviors to give the training.	A 207		
A 208	482.13(f)(4) PATIENT RIGHTS: RESTRAINT OR SECLUSION Training documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed. This STANDARD is not met as evidenced by: Based on interview and review of documentation it was determined that the facility failed to provide direct care staff and the medical staff with current training on the use of physical restraints in orientation and on a reoccurring basis. Findings include:	A 208		

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A 208	Continued From page 28 Interview with the charge nurse on 9/23/08 regarding the use of restraints revealed that she had worked at the facility for a number of years. When asked about the use of restraints she stated that they did not use restraints on the acute floor but occasionally the use of restraints had been utilized in the Emergency Room to protect the patient or staff. However she did agree that there may come a time when a restraint may be utilized on the acute floor for the same reason. When asked about training on restraints she stated she had attended training for restraint use in the past. Further questioning revealed that this training was directed at the use of restraints in the distinct part skilled nursing unit. No recent training had been provided by the facility to the direct care staff on the use of restraints. Interview with the medical director revealed that he had not been provided the updated information on the use of restraints and seclusion in the acute hospital setting. He agreed that there may be a time that a patient would need to be restrained to protect the patient or staff from harm. Interview with the director of nurses revealed that he was not aware of the reporting requirements for death in restraints. He confirmed that there had been no current training on restraints usage for the acute hospital. He was unaware of what the acute hospital's policy stated regarding the use of restraints. Review of the hospital's policy revealed the components of an accurate policy except for the reporting of death in restraints to CMS and when	A 208		

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A 208	Continued From page 29 it should be implemented. Although the hospital was not accredited by The Joint Commission, the policy also made reference to The Joint Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy.	A 208		
A 264	482.21(a) QAPI PROGRAM SCOPE Standard: Program Scope This STANDARD is not met as evidenced by: Based on a review of the hospital Quality Improvement Program and an interview with the hospital's Quality Improvement (QI) representative, the hospital does not ensure that all hospital departments are included in the hospital-wide quality assessment and improvement program, by excluding the respiratory care department from the regular QI Report Schedule. Findings include: The hospital QI representative confirmed in an interview on 9/23/08 that the respiratory care department is not included in the regular QI Report Schedule for 2008. The QI Report Schedule for 2008 had twelve departments named and did not include the respiratory care department.	A 264		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan	A 396		

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A 396	Continued From page 30 for each patient. This STANDARD is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that the nursing staff develops, and keeps current, a nursing care plan for 5 of 20 patients. (Patient #7, #11, #14, #17 and #18) Findings Include: Patient #7: The patient was admitted to the facility on 6/30/08 with a diagnosis of dehydration. The physician's progress note, dated 7/1/08, included a diagnosis of left eye conjunctivitis. No evidence was found of a nursing care plan in the patient's medical record. On 9/23/08 at 2:10 PM, the director of nurses (DON) was interviewed. He stated that the facility had identified problems with nursing care plans not being completed on the acute care side of the facility. The DON was asked if the care plan could be found in another section. The facility was not able to provide evidence that a nursing care plan had been developed for Patient #7. Patient's #14, #17 and #18 had no care plans in their medical records. This was confirmed by the Director of Nurses per fax copies and confirmation in the fax. Patient #11 had a goal but no care plan to implement the goal.	A 396		
A 405	482.23(c)(1) ADMINISTRATION OF DRUGS All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable	A 405		

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A 405	Continued From page 31	A 405		

licensing requirements, and in accordance with the approved medical staff policies and procedures.

This STANDARD is not met as evidenced by:
Based on record review and interview it was determined that the facility failed to administer drugs in accordance with the facility's approved policies and procedures for 1 of 20 sampled patients (Patient #7).

Findings Include:

Patient #7: The patient was admitted to the facility on 6/30/08 with a diagnosis of dehydration. The physician's progress note, dated 7/1/08, included a diagnosis of left eye conjunctivitis.

The director of nurses (DON) was interviewed on 9/23/08 at 3:00 PM. He stated that Patient #7's medication was considered brought into the hospital by the patient since it was dispensed during his emergency room stay.

The physician's orders, dated 07/01/08, for Patient #7 revealed that the patient was to receive Poly-trim eye drops, two drops in the left eye, four times a day.

Patient #7's, medication administration report (MAR) revealed that the item was missing on 7/1/08 at 10:45 AM, 2:19 PM, 8:54 PM and on 7/2/08 at 5:47 AM and was not done on 7/2/08 at 11:00 AM. When a medication was administered it was documented as done on the MAR.

On 9/23/08 the director of nurses (DON) stated that he spoke with the nurse regarding the eye drops. He stated that the nurse told him that

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A 405	Continued From page 32 Patient #7's eye drops were kept in the patient's drawer and the nurse had administered the eye drops. The facility's policy, titled, "Policy: Medication - Brought into the hospital by patients," revealed, "A patient's medications are never to be left at the bedside with the patient while they are hospitalized."	A 405		
A 432	482.24(a) ORGANIZATION AND STAFFING The organization of the medical record service must be appropriate to the scope and complexity of the services performed. The hospital must employ adequate personnel to ensure prompt completion, filing, and retrieval of records. This STANDARD is not met as evidenced by: Based on interview and review of the documentation it was determined that the facility's medical record department failed to have written policies and procedures in place to ensure prompt completion, filing and retrieval of records. Findings include: The medical record department was able to retrieve records easily when a random sample was selected. They had a computer software program that identified where the records were located. The head of medical records per interview on 9/25/08 was able to answer the question regarding requirements for length of time for storage, organization, necessary documentation in the medical record, HIPPA requirements and necessary time frames to be met to meet the state and federal requirements. When the head of medical records was asked	A 432		

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A 432	Continued From page 33 where their policies and procedures were kept, she could not locate the manuals. After approximately 30 minutes she provided the manuals. Review of the medical records policies documented that they had not been updated since 1991. The policies did not describe the current process being used to store medical records or any update of current state and federal requirements. The head of the medical records department confirmed the policies did not reflect current procedures in the department.	A 432		
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on interview and review of the documentation it was determined that the facility's medical record department failed to have written policies and procedures in place to ensure prompt completion, filing and retrieval of records. The facility failed to have a process in place to authenticate signatures. Findings include: The medical record department was able to retrieve records easily when a random sample was selected. They had a computer software program that identified where the records were located. The head of medical records per interview on 9/25/08 was able to answer the question regarding requirements for length of time for storage, organization, necessary	A 450		

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A 450	Continued From page 34 documentation in the medical record, HIPPA requirements and necessary time frames to be met to meet the state and federal requirements. When the head of medical records was asked where their policies and procedures were kept, she could not locate the manuals. After approximately 30 minutes she provided the manuals. Review of the medical records policies documented that they had not been updated since 1991. The policies did not describe the current process being used to store medical records or any update of current state and federal requirements. The head of the medical records department confirmed the policies did not reflect current procedures in the department. There was no policy in place to authenticate signatures.	A 450		
A 500	482.25(b) DELIVERY OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This STANDARD is not met as evidenced by: Based on interview it was determined that the facility failed to ensure the safe distribution of medications to inpatients in the facility. Findings Include: On 9/23/08 at 10:35 AM, the pharmacy technician was interviewed. She stated that the pharmacist came to the facility once a month. She stated that when the pharmacist was in the facility he reviewed medication orders for appropriateness before the first dose was dispensed. She stated	A 500		

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A 500	Continued From page 35 that when the pharmacist was not in the facility there was no mechanism in place for the pharmacist to review medication orders for appropriateness before the first dose was dispensed to inpatients.	A 500		
A 536	482.26(b)(1) SAFETY FOR PATIENTS AND PERSONNEL Proper safety precautions must be maintained against radiation hazards. This includes adequate shielding for patients, personnel, and facilities, as well as appropriate storage, use and disposal of radioactive materials. This STANDARD is not met as evidenced by: Based on an observation of the radiology department, a review of radiology department policies, and an interview with radiology department personnel, the radiology department did not ensure that patient shielding was routinely checked. Findings include: It was confirmed by radiology department personnel that periodic checks of shielding for the ability to provide radiological safety to patients did not occur.	A 536		
A 537	482.26(b)(2) PERIODIC EQUIPMENT MAINTENANCE Periodic inspection of equipment must be made and hazards identified must be promptly corrected. This STANDARD is not met as evidenced by: Based on a review of radiology department records and an interview with radiology department personnel on September 23, 2008,	A 537		

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A 537	Continued From page 36 periodic inspection of the X-ray and MRI equipment was not made. Findings include: 1. Radiology personnel confirmed that no scheduled preventive maintenance had been performed on the X-ray instrument, the Quantum QT750, serial # QG40G03K1028, since its installation on November 24, 2003. 2. Radiology personnel confirmed that there was not a preventive maintenance contract for the MRI instrument, the Toshiba KCD-10M-7A, serial #B6592488.	A 537		
A 547	482.26(c)(2) QUALIFIED STAFF Only personnel designated as qualified by the medical staff may use the radiologic equipment and administer procedures. This STANDARD is not met as evidenced by: Based on a review of the hospital's Position Description for Radiologist Technologist, a review of hospital personnel records, and an interview with radiology department personnel on September 23, 2008, two of three radiology department personnel were not qualified to use radiologic equipment. Findings include: Among the qualifications listed in the hospital's Position Description for Radiology Technologist, "Must have academic training as a Radiologist Technologist" and "AART license preferred" are items A and B. 1. One previous employee of the department,	A 547		

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A 547	Continued From page 37 who transferred from within the hospital on May 24 of 2007, did not have academic training in Radiology, and did not possess an American Registry of Radiologic Technologists license. 2. One current employee of the department, who transferred from within the hospital on June 23 of 2008, does not have academic training in Radiology, and does not possess an American of Radiologic Technologists license.	A 547		
A 592	482.27(b) POTENTIALLY INFECTIOUS BLOOD/BLOOD PRODUCTS Standard: Potentially infectious blood and blood products. (1) Potentially human immunodeficiency virus (HIV) infectious blood and blood components. Potentially HIV infectious blood and blood components are prior collections from a donor - (i) Who tested negative at the time of donation but tests reactive for evidence of HIV infection on a later donation; (ii) Who tests positive on the supplemental (additional, more specific) test or other follow-up testing required by FDA; and (iii) For whom the timing of seroconversion cannot be precisely estimated. (2) Potentially hepatitis C virus (HCV) infectious blood and blood components. Potentially HCV infectious blood and blood components are the blood and blood components identified in 21 CFR 610.47. (3) Services furnished by an outside blood collecting establishment. If a hospital regularly uses the services of an outside blood collecting establishment, it must have an agreement with	A 592		

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the blood collecting establishment that governs the procurement, transfer, and availability of blood and blood components. The agreement must require that the blood collecting establishment notify the hospital --

(i) Within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of HIV or HCV infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection;

(ii) Within 45 days of the test, of the results of the supplemental (additional, more specific) test for HIV or HCV, as relevant, or other follow-up testing required by FDA;

(iii) Within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available, as set forth at 21 CFR 610.48(b)(3).

(4) Quarantine of blood and blood components pending completion of testing. If the blood collecting establishment (either internal or under an agreement) notifies the hospital of the reactive HIV or HCV screening test results, the hospital must determine the disposition of the blood or blood component and quarantine all blood and blood components from previous donations in inventory.

(i) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is negative, absent other informative test results, the hospital may release the blood and blood components from quarantine.

(ii) If the blood collecting establishment notifies the hospital that the result of the supplemental

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(additional, more specific) test or other follow-up testing required by FDA is positive, the hospital must -

(A) Dispose of the blood and blood components; and

(B) Notify the transfusion recipients as set forth in paragraph (b)(6) of this section.

(iii) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is indeterminate, the hospital must destroy or label prior collections of blood or blood components held in quarantine as set fors at 21 CFR 610.46(b)(2), 610.47(b)(2), and 610.48(c)(2).

(5) Recordkeeping by the hospital. The hospital must maintain --

(i) Records of the source and disposition of all units of blood and blood components for at least 10 years from the date of disposition in a manner that permits prompt retrieval; and

(ii) A fully funded plan to transfer these records to another hospital or other entity if such hospital ceases operation for any reason.

(6) Patient notification. If the hospital has administered potentially HIV or HCV infectious blood or blood components (either directly through its own blood collecting establishment or under an agreement) or released such blood or blood components to another entity or appropriate individual, the hospital must take the following actions:

(i) Make reasonable attempts to notify the patient, or to notify the attending physician who ordered the blood or blood component and ask the physician to notify the patient, or other individual as permitted under paragraph (b)(10) of

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this section, that potentially HIV or HCV infectious blood or blood components were transfused to the patient and that there may be a need for HIV or HCV testing and counseling.

(ii) If the physician is unavailable or declines to make the notification, make reasonable attempts to give this notification to the patient, legal guardian or relative.

(iii) Document in the patient's medical record the notification or attempts to give the required notification.

(7) Timeframe for notification.

(i) For donors tested on or after February 20, 2008. For notifications resulting from donors tested on or after February 20, 2008 as set forth at 21 CFR 610.46 and 21 CFR 610.47 the notification effort begins when the blood collecting establishment notifies the hospital that it received potentially HIV or HCV infectious blood and blood components. The hospital must make reasonable attempts to give notification over a period of 12 weeks unless--

(A) The patient is located and notified; or

(B) The hospital is unable to locate the patient and documents in the patient's medical record the extenuating circumstances beyond the hospital's control that caused the notification timeframe to exceed 12 weeks.

(ii) For donors tested before February 20, 2008. For notifications from donors tested before February 20, 2008 as set forth at 21 CFR 610.48(b) and (c), the notification effort begins when the blood collecting establishment notifies the hospital that it received potentially HCV infectious blood and blood components. The hospital must make reasonable attempts to give notification and must complete the actions within 1 year of the date on which the hospital received

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A 592	Continued From page 41 notification from the outside blood collecting establishment. (8) Content of notification. The notification must include the following information: (i) A basic explanation of the need for HIV or HCV testing and counseling. (ii) Enough oral or written information so that an informed decision can be made about whether to obtain HIV or HCV testing and counseling. (iii) A list of programs or places where the person can obtain HIV or HCV testing and counseling, including any requirements or restrictions the program may impose. (9) Policies and procedures. The hospital must establish policies and procedures for notification and documentation that conform to Federal, State, and local laws, including requirements for the confidentiality of medical records and other patient information. (10) Notification to legal representative or relative. If the patient has been adjudged incompetent by a State court, the physician or hospital must notify a legal representative designated in accordance with State law. If the patient is competent, but State law permits a legal representative or relative to receive the information on the patient's behalf, the physician or hospital must notify the patient or his or her legal representative or relative. For possible HIV infectious transfusion recipients that are deceased, the physician or hospital must inform the deceased patient's legal representative or relative. If the patient is a minor, the parents or legal guardian must be notified. (11) Applicability. HCV notification requirements	A 592		

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A 592	Continued From page 42 resulting from donors tested before February 20, 2008 as set forth at 21 CFR 610.48 will expire on August 24, 2015. This STANDARD is not met as evidenced by: Based on a review of the laboratory's Look Back Procedure, reviewed by the laboratory director in April of 2008, and an interview with laboratory personnel on September 23, 2008, the laboratory failed to have in place a Look Back procedure which addressed each requirement of CFR 482.27(b), including updating the policy to include HCV where indicated. Findings include: The hospital laboratory Look Back procedure did not include all of the requirements of CFR 482.27(b), including: 1. Recipient notification to continue for 12 weeks 2. Recordingkeeping by the hospital 3. HCV testing, notification, counselling, etc. as indicated by the revisions to CFR 482.27(b) 4. Notification of relative or legal representative or guardian as needed or required 5. Steps to take when follow-up testing results are indeterminate	A 592		
A 620	482.28(a)(1) DIRECTOR OF DIETARY SERVICES The hospital must have a full-time employee who- (i) Serves as director of the food and dietetic services;	A 620		

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A 620	Continued From page 43 (ii) Is responsible for daily management of the dietary services; and (iii) Is qualified by experience or training. This STANDARD is not met as evidenced by: Based on staff interview and facility documentation review, it was determined the facility failed to ensure that a registered dietitian served as the director of the food and dietetic services department and failed to conduct a nutritional screening, assessment and referral for nutrition education for 5 of 20 patients. (Patient #6, #7, #8, #16 and #19) Findings include: Review of the dietitian's contract revealed that the contract allowed for 6 hours every quarter for nutrition and dietetic services for the long term care unit (skilled nursing unit) but not the hospital. The dietitian stated during a telephone interview on 9/23/08 in the afternoon, that she did not provide in-service training for dietary staff, did not review or approve therapeutic menus or develop menus if needed, and did not provide discharge diet instruction, or nutritional assessments for hospital patients. She indicated during the interview that she would like to be involved with revising policies and procedures and diet instruction materials for patients. Her understanding of the services she was to provide, the terms of services in the current contract and allowable work hours did not include these services. The Dietary Manager completed the dietary	A 620		

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A 620	Continued From page 44 managers course on 10/29/05, however the dietitian does not provide instruction to the manager on how to serve therapeutic diets for some hospital patients. This has resulted in the physician changing diet orders to less restrictive dietary levels. This is due to the lack of knowledge and training provided to the dietary manager in the absence of the dietitian. Patient #19 was a newly diagnosed Diabetic type 2 and also had the diagnosis of obesity. Review of the medical record indicated that an LPN on staff had provided diabetic teaching. No involvement was noted by a dietitian. Patient #16 was diagnosed with atrial fibulation and congestive heart disease, large pleural effusion and diabetes mellitis type 2. The medical record documented that the education of the diabetic diet was provided by an LPN on staff. Interview with the LPN revealed that she did provide the diabetes education, including the diet instructions. She stated she did it because her daughter had diabetes and that is how she had acquired the knowledge to provide the education along with her nursing education. The dietitian had not approved the educational process for instructions for the diabetic diet education. The facility's policy titled, "Nutrition Screening and Assessment in the Absence of a full-time registered dietitian,' revealed: "1. The Registered Dietitian will be "on-call" when absent from the facility. 2. The "nutritional screening" form will be completed by a RN on every hospitalized patient (if the patient is not at high risk, RN only needs to complete the last two (2) lines.)" Number three included the following diagnoses and/or conditions as "high nutritional risk":	A 620		

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A 620	Continued From page 45 malnutrition, renal failure, sepsis, poorly controlled diabetes and others. "4. If the hospitalized patient is deemed at "high nutritional risk", then the RN will fax the Nutrition Screening form, current medications, lab results, History and Physical, and the Nursing Assessment form to the Registered Dietician within 48 hours of admission. 5. The Registered Dietitian will then complete the initial Nutritional Assessment and will make nutritional recommendations within 24 hours of receipt of the referral." Patient #6: The patient was admitted to the facility on 6/25/08 with diagnoses of pneumonia, bone cancer, hypokalemia and malnutrition. The patient would be considered to be at high nutritional risk according to the facility's policy. There was no evidence found that a nutritional screening was completed or that the registered dietician completed an initial nutritional assessment and nutritional recommendations. Patient #7: The patient was admitted to the facility on 6/30/08 with a diagnosis of dehydration. The physician's progress note, dated 7/1/08, included a diagnosis of left eye conjunctivitis. Patient #7's laboratory values, dated 6/30/08, revealed the patient has a total protein level of 9.6 and an albumin level of 6.0. The patient's lab values, dated 7/1/08, revealed the patient's total protein level was 5.4 and his albumin level was 2.9. A normal total protein level for this patient would be 6.3 to 8.2 and a normal albumin level would be 3.5 to 5.0. The patient was dehydrated which would contribute to the high levels on 6/30/08; he was then hydrated. After he was hydrated his levels fell below normal.	A 620		

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A 620	Continued From page 46 There was no evidence found in Patient #7's record that a nutritional screening form was completed. There was no evidence found that the low albumin levels were evaluated to determine if the cause was over-hydration or malnutrition. Patient #8: The patient was admitted to the facility on 7/5/08 with diagnoses that included renal insufficiency, cirrhosis, diabetes, and anemia. The patient would be considered to be at high nutritional risk according to the facility's policy. There was no evidence found that a nutritional screening was completed or that the registered dietician completed an initial nutritional assessment and nutritional recommendations. The dietitian stated during a telephone interview on 9/23/08, in the afternoon, that she was used primarily for the skilled nursing facility residents. She stated that she had been involved in only one hospital patient case in the last three years. The Medical Director stated that if a dietician was available for the inpatients he was not aware of it. He stated he would like to see dietician services provided at the facility.	A 620		
A 621	482.28(a)(2) QUALIFIED DIETITIAN There must be a qualified dietitian, full-time, part-time, or on a consultant basis. This STANDARD is not met as evidenced by: Based on review of facility documents, staff interview and patient medical record review, it was determined the facility failed to have a dietitian providing nutrition and dietetic services to 20 of 20 acute care hospital patients.	A 621		

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A 621	Continued From page 47 Findings include: Review of the dietitian's contract revealed that the contract allowed for 6 hours every quarter for nutrition and dietetic services for the long term care unit (skilled nursing unit) but not the hospital. The dietitian stated during a telephone interview on 9/23/08 in the afternoon, that she did not provide in-service training for dietary staff, did not review or approve therapeutic menus or develop menus if needed, and did not provide discharge diet instruction, or nutritional assessments for hospital patients. She indicated during the interview that she would like to be involved with revising policies and procedures and diet instruction materials for patients. Her understanding of the services she was to provide, the terms of services in the current contract and allowable work hours did not include these services. There was no quality assurance plan for the dietary department related to the acute care hospital.	A 621		
A 622	482.28(a)(3) COMPETENT DIETARY STAFF There must be administrative and technical personnel competent in their respective duties. This STANDARD is not met as evidenced by: Based on observation it was determined that the facility staff failed to maintain the kitchen in a clean and sanitary manner. Findings include: There were three White Westinghouse reach-in	A 622		

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A 622	Continued From page 48 refrigerators that were not commercial grade and that had torn seals on the interior of the doors. One carton of heavy whipping cream in the middle refrigerator had an expiration date of 9/4/08. The reach-in "Conservator" freezer was in need of cleaning due to a build-up of food debris on the interior of the unit. One bag of hash browns was not re-sealed completely after opening or dated. There were multiple food products stored in plastic bags purchased from "Sysop". There was no documentation available to verify the plastic bags were food grade safe and appropriate for freezing food items. There were burned out light bulbs in the dry food storage room. The following food items were not resealed completely after being opened: one bag of spaghetti noodles, cake mix, banana pudding mix, sugar free butterscotch pudding, vanilla instant pudding mix and cornbread mix. One package of instant pudding mix had been opened and resealed but was not dated. Bread crumbs were being stored in a non NSF approved food grade storage container. One employee was consuming a soft drink beverage in the kitchen during food preparation.	A 622		
A 628	482.28(b) DIETS Menus must meet the needs of the patients. This STANDARD is not met as evidenced by: Based on review of the facility menus, the facility did not ensure the menus were approved by the dietitian or meet the needs of the patients. Findings include:	A 628		

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A 628	Continued From page 49 The menus were from Crandall and Associates and were dated 2002. There was no documentation to verify the dietitian approved the menus as nutritionally adequate for the hospital patients.	A 628		
A 631	482.28(b)(3) THERAPEUTIC DIET MANUAL A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing, and food service personnel. This STANDARD is not met as evidenced by: Based on review of facility documentation the facility failed to have a current therapeutic diet manual available for staff. Findings include: Review of the "Contemporary Nutrition and Diet Handbook" provided by facility staff revealed that the medical staff and dietitian did not review or approve the use of this handbook as the therapeutic diet manual. The handbook was last revised in 2004.	A 631		
A 747	482.42 INFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to have an active program for the prevention, control, and	A 747		

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A 747	Continued From page 50 investigation of infections and communicable diseases for patients. Findings include: The following processes were not in place as evidence by: CFR 482.42(a) (A 0748) The infection control officer was not qualified by education or training to perform the duties of an infection control officer. CFR 482.42(a)(1) (A 0749) No active surveillance system was in place for infections and communicable diseases that occurred in the facility for patients. CFR 482.42(a)(2) (A 0750) No log of incidents related to infections and communicable disease was maintained by the facility.	A 747		
A 748	482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on interview and personnel record review it was determined that the facility failed to designate in writing an infection control officer that was qualified through education and/or training. Findings Include: On 9/23/08 at 9:30 AM, the director of nurses (DON) was interviewed. He stated that he also served as the facility's infection control officer. He stated that he did not have specialized training in infection control; he did not have any certifications in infection control and his	A 748		

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A 748	Continued From page 51 experience was not in infection control. The DON's personnel file was reviewed. There was no evidence found in the DON's personnel file which revealed that he had specialized training or certification in infection control.	A 748		
A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on interview it was determined that the facility failed to develop a system for identifying, investigating and controlling infections of patients in the facility. Findings Include: On 9/24/08 at 11:50 AM, the director of nurses (DON) was interviewed. The DON also served as the facility's infection control officer. The DON was asked how infection control surveillance was being conducted at the facility for patients. He stated that patient cultures were in the system and that he was going to devise a log for cultures but it had not been implemented yet. He was asked how he would be able to determine if positive cultures were a result of a hospital acquired infection. He did not have a system in place to determine this. The facility had a policy titled, "Infection Control Surveillance." The policy revealed, "Surveillance of microorganisms shown on cultures: Although this is not a good indicator of the number of infections in the facility, review and analysis of culture sensitivities may serve as	A 749		

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A 749	Continued From page 52	A 749		

an alert to a problem (e.g., multiresistant organisms, cross-contamination). There was no evidence found that the data from the cultures was being reviewed and analyzed.

The DON/infection control officer did not have an active surveillance program in place for patients and was not following the facility's infection control surveillance policy.

On 9/22/08 observations were made of sterile packages, ready for patient use, processed at the facility. One chest tube tray was observed with dried water marks on the package. Two sterile peel packs with a sterilized instrument in each pack were observed to have dried water marks on the packages. Three suture sets were observed to have dried water marks on the package. The Association for the Advancement of Medical Instrumentation (AAMI) Sterilization in Health Care Facilities manual, 2006-2007 Edition, revealed that items removed from sterilizers should be visually inspected and that packages that appear to be wet should not be used. The AAMI manual revealed, "Items with torn or wet packaging are considered contaminated. Wet packaging might indicate problems with package composition, loading procedures, sterilizer performance or operation, or the steam generation and distribution system."

On 9/22/08 observations were made that internal chemical indicators (CI) were not observed in all of the peel packs with sterilized instruments in them. The outer packages of the peel packs had an indicator. The AAMI manual revealed "An internal CI should be used within each package, tray, or rigid sterilization container system to be sterilized." "Internal CIs should be used in the

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A 749	Continued From page 53 routine monitoring of items sterilized." On 9/23/08 observations were made that not all sterile packages were labeled with a lot number, date and initial of the person who processed the sterile package. The facility did not maintain a log of the loads run, the dates the loads were run, the lot numbers of the loads run, the specific contents of the loads run and the initials of the operator. The AAMI manual revealed, "For each sterilization cycle the following information should be recorded and maintained: a) the lot number b) the specific contents of the lot or load, including quantity, department, and a specific description of the items (e.g. towel packs, type/name of instrument sets): c) The exposure time and temperature, if not provided on there sterilizer recording chart d) the name or initials of the operator e) the results of biological testing, if applicable g) the response of the CI placed in the PCD ... h) any reports of inconclusive or nonresponsive CI's found later in the load" "Rationale: Documentation ensures that the sterilization process is monitored as it is occurring, ensures that cycle parameters have been met, and establishes accountability. In addition, documentation helps personnel determine whether a recall is necessary should evidence subsequent to lot release, such as a positive BI (biological indicator) or nonresponsive CI (chemical indicator), suggest sterility problems. Knowing the contents of the lot or load enables personnel to identify the medical devices to be recalled." "In addition, this documentation provides evidence of the department's quality control program."	A 749		

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A 749	Continued From page 54 The person identified as being in charge of sterilizing instruments was interviewed on 9/23/08 at 5:20 PM. She was shown the packages with water stains on them. She stated that the autoclave had a dry cycle but she did not indicate that she participated in the drying of the instruments. The AAMI manual revealed that cracking the sterilizer door after the drying phase allows for slow cooling to minimize condensation. She was also asked how the laryngoscope blades were processed. She stated that she would clean them, remove the light, autoclave the blades and then reapply the light. The light was not being sterilized. The light enters the mouth during intubation and may touch mucus membranes. The AAMI manual revealed that "semicritical devices are instruments or objects that contact intact mucus membranes..." The Centers for Disease Control and Prevention's "Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Setting 2007 revealed: "IV.E. Patient-care equipment and instruments/devices: IV.E.2. Remove organic material from critical and semi-critical instrument/devices, using recommended cleaning agents before high level disinfection and sterilization to enable effective disinfection and sterilization processes." The person identified as being in charge of sterilization was asked about her qualifications to sterilize instruments. She indicated that she was taught how to process instruments from the nurse who had the job before her. She stated that this training occurred in the 1990's. She stated that she had not received any further training on the sterilization process since the 1990's. She stated	A 749		

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A 749	Continued From page 55	A 749		

that she did not have a certification in sterile processing and did not receive any ongoing training or any training specific to the new autoclave the facility had purchased. She was not aware of the standards of practice the facility used for sterilization. She was not aware the facility had both the Association of periOperative Nurse's standards of practice and the AAMI's manual in the facility for reference. The AAMI manual revealed, "The responsibility for sterile processing should be assigned to qualified individuals who have demonstrated competence in all aspects of sterile processing: decontamination, preparation, packaging, sterilization, sterile storage, and distribution of sterile medical devices."

The facility's currently adopted policies and procedures for sterilization were reviewed. The policy was dated 1997. The policy consisted of pages which had the names of packs on the top and what each pack contained. The policy did not address the sterilization process or current standards of practice. The DON did have new policies that had been developed using current standards of practice but had not yet been approved by the governing body for use in the facility. The DON stated the facility planned on adopting the standards of practice set forth by AAMI at the next governing body meeting.

Observations were made on 9/23/08 of the facility's decontamination/sterilization room. Dirty instruments were brought into the room and decontaminated and processed in the same room in which the instruments were sterilized. Observations were made of sterile items in the same room that instruments were decontaminated in. The facility had a separate

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A 749	Continued From page 56 room which could be used for the decontamination of instruments. The person identified as in charge of sterilization was interviewed regarding biological testing. She stated the facility had a new autoclave. One load of instruments had been run in the new autoclave and put in stock for patient use. A biological indicator had never been run on the new autoclave prior to running the load of instruments to ensure the autoclave was effectively sterilizing the instruments. The AAMI manual revealed, "Rationale: Biological indicators are the only sterilization process monitoring device that provides a direct measure of the lethality of the process." The new autoclave was in the facility in August of 2008. At least one load of instruments had been run in the autoclave. Observation were made that the trays in the autoclave had some staining on them. The person in charge of sterile processing stated that the facility had not started the autoclave's maintenance schedule because it was a new autoclave. The manufacturer's instructions revealed the autoclave had daily, weekly and other maintenance needs. The AAMI manual revealed, "Sterilizers should be inspected and cleaned daily according to the manufacturer's written instructions..." "Weekly or other prescribed inspection and cleaning should be performed as specified in the manufacturer's written instructions. Rationale: Periodic inspection and cleaning reduce the frequency of equipment malfunction and the risk of accidental contamination of sterile items." On 9/22/08 at 6:00 PM, two cleaning solutions	A 749		

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A 749	Continued From page 57 were noted in the emergency room patient care areas. One spray bottle was labeled bleach water and one was labeled all purpose cleaner. The charge nurse stated that staff could use either cleaner to clean the patient care area between patients. On 9/24/08 at 11:30 AM, the plant manager was interviewed regarding the cleaning solutions. He stated that he did not know what the all purpose cleaner was. The label on the all purpose cleaner did not identify it as registered with the Environmental Protection Agency (EPA) or as a hospital grade cleaner. The plant manager stated that the bleach solution was mixed one part bleach to ten parts water. It was not clear if this bleach concentration met EPA standards. The plant manager revealed that the facility had an EPA registered cleaner available for cleaning patient care areas. The Centers for Disease Control and Prevention's "Guidelines for Environmental Infection Control in Health-Care Facilities," revealed: "I. Cleaning and Disinfecting Strategies for Environmental Surfaces in Patient-Care Areas A. Select EPA-registered disinfectants, if available, and use them in accordance with the manufacturer's instructions." "E. 1. Use a one-step process and an EPA-registered hospital detergent/disinfectant designed for general housekeeping purposes in patient-care areas where 1) uncertainty exists as to the nature of the soil on the surfaces (e.g., blood or body fluid contamination versus routine dust or dirt); or 2) uncertainty exists regarding the presence of multidrug resistant organisms on such surfaces." During observation in the emergency room on 9/22/08, it was noted that on the shelves were a number of Foley catheter trays. There were four	A 749		

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A 749	Continued From page 58 (4) outdated trays on the bottom of trays that were not outdated. Staff failed to rotate stock to ensure that outdated supplies were not available for use on patients.	A 749		
A 750	482.42(a)(2) INFECTION CONTROL LOG The infection control officer or officers must maintain a log of incidents related to infections and communicable diseases. This STANDARD is not met as evidenced by: Based on interview it was determined that the facility failed to maintain a log of incidents related to infections and communicable diseases. Findings Include: On 9/24/08 the director of nursing (DON) was interviewed. He stated that he also acted as the facility's infection control officer. He stated that the facility did not maintain a log of incidents related to infections and communicable diseases.	A 750		
A 800	482.43(a) CRITERIA FOR DISCHARGE EVALUATIONS The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. This STANDARD is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to identify for 1 of 20 patients the need for adequate discharge planning to address psychiatric needs. (Patient #17) Findings include:	A 800		

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A 800	Continued From page 59 Patient #17: The patient was admitted on 6/11/08 with a documented diagnosis of "intentional overdose, suicidal ideations, anxiety". It was stated throughout the physicians documentation that the patient would not sign a suicide contract until the day he was discharge. There was no documentation that the patient had been referred to psychological services or that the physician had discussed his case with the patient's previous psychiatrist. No discharge documentation was found addressing psychiatric services referral or psychiatric followup for the patient. Patient #17 was readmitted on 6/25/08 to the emergency room. The diagnosis was "cutting throat, attempted suicide". As result of this visit to the emergency room the attending physician had flown him to another major hospital to obtain psychiatric services. During an interview with the risk manager who also worked as a charge nurse on the floor regarding this case, she stated she was aware of this case. She stated that the community had no resources. However, further investigation revealed that there was a mental health clinic that was serviced by the State Mental Health system that was open in the community on a regular basis each month on specified days. Review of the medical record also revealed that the attending physician had recommended a social services consult to obtain a referral for disability. Interview with the social worker on 9/24/08 it was stated that she had done the disability referral. However, when the social worker was asked if she had asked the physician or the patient about a psychiatric referral or follow-up she stated she had not.	A 800		

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A 800	Continued From page 60 No discharge planning was documented on the first admission to refer this patient to psychiatric services to possibly prevent a readmission for attempted suicide.	A 800		
A 884	482.45 ORGAN, TISSUE, EYE PROCUREMENT Organ, Tissue and Eye Procurement This CONDITION is not met as evidenced by: Based on interview it was determined that the facility failed to ensure that specific organ, tissue, and eye procurement requirements were met. Findings Include: There was no contract or collaboration with an organ procurement organization to ensure that specific organ, tissue and eye procurements requirements were met.	A 884		
A 885	482.45(a) WRITTEN POLICIES AND PROCEDURES The hospital must have and implement written protocols that: This STANDARD is not met as evidenced by: Based on interview it was determined that the facility failed to implement the facility's organ procurement policy. Findings Include: On 9/25/08, the charge nurse and a registered nurse were interviewed regarding the facility's organ procurement policy. They stated that the organ procurement organization (OPO) was to far away and would not come to the facility. The charge nurse also stated that there was no	A 885		

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A 885	Continued From page 61 refrigerator available at the hospital for organ procurements. She did not mention keeping the patient on a ventilator until the OPO arrived. On 9/25/08, the administrator stated he had found an OPO that would come to the facility. The facility's policy on organ procurement revealed, "Federal law requires that all deaths be reported to the local organ procurement organization. If a patient is a potential organ donor (neurologically insulted and on a ventilator), federal law requires that the organ procurement organization be called when death is imminent." "Why is a ventilator important to organ transplantation? In order to keep donated organs functioning before transplantation, a ventilator must be in use. Organs deteriorate rapidly once death occurs; if the patient is not on a ventilator the organs will not be usable for transplantation."	A 885		
A 886	482.45(a)(1) OPO AGREEMENT Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the hospital, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the hospital for this purpose; This STANDARD is not met as evidenced by: Based on interview it was determined that the	A 886		

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A 886	Continued From page 62 facility failed to have a written agreement with an Organ Procurement Organization. Findings Include: On 9/25/08 at 1:50 PM, the administrator stated the facility did not have a contract with an Organ Procurement Organization.	A 886		
A 888	482.45(a)(3) INFORMED FAMILY Ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its options to donate organs, tissues, or eyes, or to decline to donate. This STANDARD is not met as evidenced by: Based on interview it was determined that the facility failed to ensure, in collaboration with the organ procurement organization, that the family of each potential donor was informed of its options to donate organs, tissues, or eyes, or to decline to donate. Findings Include: On 9/25/08 at 1:50 PM, the administrator stated the facility did not have a contract with an Organ Procurement Organization (OPO). On 9/25/08, the charge nurse and a registered nurse were interviewed regarding the facility's organ procurement policy. They stated that the OPOs are too far away and would not come to the facility. The charge nurse also stated that there was no refrigerator available at the hospital for organ procurements. She did not mention keeping the patient on a ventilator until the OPO arrived.	A 888		

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A 888	Continued From page 63 On 9/25/08, the administrator stated he had found an OPO that would come to the facility. There was no evidence found that the facility worked in collaboration with the OPO to ensure that the family of each potential donor was informed of its options to donate organs or to decline to donate.	A 888		
A 889	482.45(a)(3) DESIGNATED REQUESTOR The individual designated by the hospital to initiate the request to the family must be an organ procurement representative or a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation. This STANDARD is not met as evidenced by: Based on interview and document review it was determined that the facility failed to have a process in place to initiate the request for organ or tissue donation to the family. Findings Include: On 9/25/08 at 1:50 PM, the administrator stated the facility did not have a contract with an Organ Procurement Organization (OPO). On 9/25/08, the charge nurse and a registered nurse were interviewed regarding the facility's organ procurement policy. They stated that the OPOs are too far away and would not come to the facility. The charge nurse also stated that there was no refrigerator available at the hospital	A 889		

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A 889	Continued From page 64 for organ procurements. She did not mention keeping the patient on a ventilator until the OPO arrived. On 9/25/08, the administrator stated he had found an OPO that would come to the facility.	A 889		
A1101	482.55(a) ORGANIZATION AND DIRECTION Organization and Direction. If emergency services are provided at the hospital -- This STANDARD is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure the emergency room was supplied with necessary supplies to ensure the safety of pediatric patients. Findings Include: On 9/22/08 at 5:35 PM, there were no pediatric defibrillator pads observed in the emergency room. On 9/25/08 at 3:35 PM, the director of nurses confirmed that there were no pediatric defibrillator pads in the emergency room. He stated that they were on back order.	A1101		
A1152	482.57(a) ORGANIZATION OF RESPIRATORY CARE SERVICES The organization of the respiratory care services must be appropriate to the scope and complexity of the services offered. This STANDARD is not met as evidenced by: Based on a review of the Grover C. Dils Acute Care Policies and Procedures manual, an interview with the respiratory therapist, and an interview with the hospital CEO, the scope and	A1152		

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A1152	Continued From page 65 complexity of the respiratory services offered has not been defined in writing, and therefore it cannot be determined if the services provided are adequate and if the services provided are within the acceptable standards of practice. Findings include: There is no evidence that the gamut of respiratory services provided by the hospital is in writing. The respiratory therapist provided a verbal list of the services provided by the hospital. There is no evidence that the services provided are offered in accordance with the acceptable standards of practice, except for the individual licenses and certifications held by the respiratory therapist and the other healthcare providers who perform and assist with intubation and ventilator management for codes, oxygen services, breathing treatments, the pulse-oximeter, blood gases, and pulmonary function studies.	A1152		
A1153	482.57(a)(1) DIRECTOR OF RESPIRATORY SERVICES There must be a director of respiratory care services who is a doctor of medicine or osteopathy with the knowledge, experience and capabilities to supervise and administer the service properly. The director may serve on either a full-time or part-time basis. This STANDARD is not met as evidenced by: Based on an interview with the respiratory therapist and a review of hospital policies, the medical director duties and the medical director's personnel file, the hospital does not have a director of respiratory care services who is qualified to oversee the department.	A1153		

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A1153	Continued From page 66 Findings include: 1. There was no evidence of a hospital organizational chart which defined and named a director of the respiratory care department. 2. The medical director of the hospital, who serves in the role of the director of respiratory services, does not have the education or experience to function in this role. 3. There is no evidence that the medical director has participated in the oversight of the department.	A1153		
A1160	482.57(b) RESPIRATORY CARE SERVICES POLICIES Services must be delivered in accordance with medical staff directives. This STANDARD is not met as evidenced by: Based on a review of the Grover C. Dils Medical Center Acute Care Policies and Procedures manual provided for the surveyor by the Director of Nursing, an interview with the respiratory therapist, and an interview with the hospital CEO, there exists no documentation that the respiratory services provided by the hospital have been approved by the medical staff. Findings include: Hospital staff were unable to provide for the surveyor a comprehensive list of the respiratory services provided by the hospital which had been approved by the medical staff.	A1160		
A1161	482.57(b)(1) RESPIRATORY CARE PERSONNEL POLICIES	A1161		

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A1161	Continued From page 67 Personnel qualified to perform specific procedures and the amount of supervision required for personnel to carry out specific procedures must be designated in writing. This STANDARD is not met as evidenced by: Based on a review of the personnel file of the respiratory therapist, a review of the Grover C. Dils Medical Center Acute Care Policies and Procedures manual, and an interview with the respiratory therapist, the personnel qualified to perform specific procedures and the amount of supervision required to do so was not designated in writing. Findings include: 1. A list of respiratory procedures provided by the hospital was not available, and therefore, except for the positive and non-positive pressure breathing aerosol therapy procedures found in the hospital's acute care procedure manual and the blood gas procedures offered by the laboratory, a list of those personnel qualified to perform specific procedures and their supervision requirements was not designated in writing.	A1161		